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ABSTRACT

The School-Community Health Alliance for Rural Practitioners (SCHARP) was planned and implemented to address the severe health education and service problems faced by school children and citizens of rural America. Small rural school and communities lack the resources, expertise, and leverage to influence public policy to address these needs. This report describes the potential of higher education partnerships in promoting health and well being in small, rural schools and communities. The SCHARP project is built around three important concepts: (1) the integration of school and community health and social support services; (2) the parallel integration of the school and community health curriculum across all subject matter; and (3) the brief and intense training of a school-community health practitioner. The first three sections of the report outline the nature of the SCHARP intervention--the summer regional academies, the context of the local site, and the services used to support the local practicum. The following three sections then explore various ways to extend or reinforce the efficacy of the SCHARP model, including professional recognition, educational technology, and systemic improvements. The report concludes with a brief summary of lessons learned to guide those who may wish to employ similar approaches. Three attachments are: (1) The Allensworth and Kolbe Model of comprehensive health; (2) Outline of Academy I and Academy II; and (3) Practitioner Self Report. Contains 18 references. (RJM)

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Early to Rise:

A Guide to the Professional Development of Rural Health Educators

Rural Education Program
Northwest Regional Educational Laboratory

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1995, NWREL, Portland, Oregon

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INTRODUCTION

Many principles set forth by Benjamin Franklin in 'Poor Richard's Almanac' remain a daily routine in the rural Northwest. 'Early to bed--early to rise....' With Ben Franklin clearly connecting health, knowledge and prosperity, so his adage holds several metaphoric lessons for this guidebook. Perhaps 'Poor Richard's' most important lesson for readers of this report is to actively seek opportunity. This report is about early risers in rural Northwest schools, about individuals who did not wait for others to resolve community health issues. It is about those who stepped forward to become leaders who would inspire others toward community health. It is about a dawn-to-dusk dedication to make a contribution to rural schools and communities, and to share the lessons learned so that other health educators may benefit.

The School-Community Health Alliance for Rural Practitioners (SCHARP) Project was planned and implemented to address the severe health education and service problems faced by school children and citizens of rural America.

More than half of the nation's 16,000 school districts are small and rural. A significant proportion of children attending these schools are poor, less healthy, and less educated than the average American child. Conditions which place these children at risk are more severe than in inner-city settings. Further, small rural schools and communities lack the resources, expertise, and leverage to influence public policy to fully address these needs. The nation's goals for comprehensive school health education cannot be achieved without addressing these rural school and community issues.

The SCHARP Project is built around three important concepts: (1) the integration of school and community health and social support services, (2) the parallel integration of the school and community health curriculum across all subject matter, and (3) the brief and intense training of a school-community health practitioner. This individual, housed in a rural elementary school, receives post-baccalaureate training and internship experiences to perform a leadership role in school health education curriculum, school and community inservice, and community health promotion outreach.

The three-year project, funded by a FIRST grant from the U. S. Department of Education, was led by the Northwest Regional Educational Laboratory in cooperation with the University of Alaska/Fairbanks, Eastern Washington University, Idaho State University, Portland State University, and the University of Montana. During the summers of 1993 and 1994, an academy--an intense two-week regional summer program--was conducted. Each practitioner returned home armed with an action plan which had been developed during the two-week session. Their mission was to implement the plan the best they could in a cooperative, collaborative manner within the school and community. They were also equipped with various instructional materials provided at the two-week academy and $500 to purchase additional materials they found necessary to carry out their plans during the school year. These local efforts are described in a companion document, *Voices from the*

Wilderness: An Idea Book for Rural Health Educators. But SCHARP is also about creating a professional development system to support these rural school and community activities. *Early to Rise: A Guide for the Professional Development of Rural Health Educators* provides this broader view.

The purpose of this report is to describe the potential of higher education partnerships to instill local leadership in small, rural schools and communities to comprehensively promote health and well being. The first three sections of the report describe the nature of the SCHARP intervention--the summer regional academies, the context of the local sites and the services used to support the local practicum. The second three sections then explore various ways to extend or reinforce the efficacy of the SCHARP model, including professional recognition, educational technology, and systemic improvements. The report concludes with a brief summary of valuable lessons to guide those who may wish to employ similar approaches.

This report, like the SCHARP Project as a whole, was a collaborative effort among many individuals and institutions. Of particular note are the primary authors of the various sections of the report, including Maxine Thomas and Leslie McBride of Portland State University, Robert Salsbury of Eastern Washington University, Richard Kearns of Idaho State University, Kathleen Miller of the University of Montana, Tom Wells of the University of Alaska/Fairbanks, and Helen J. Sjolander of the Northwest Regional Educational Laboratory.

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1
THE SCHARP ACADEMIES

The SCHARP model entails higher education support of a two-pronged practitioner program--a two-week intensive training academy held regionally during the summer, followed by field practicum experience throughout the school year. This chapter describes the university faculty involvement in the summer academy portion of the program.

The three-year School and Community Health Alliance for Rural Practitioners (SCHARP) Project included a two-week regional summer program for 15 rural school practitioners selected from the five Northwest states. The Northwest Regional Educational Laboratory (NWREL), in cooperation with the University of Alaska/Fairbanks, Eastern Washington University. Idaho State University, the University of Montana and Portland State University, identified rural schools in districts that enrolled less than 2,500 students and were located 30 or more miles from a population center of 15,000 or more. "Rural" was defined as 75 percent or more of the district students living in unincorporated areas or in incorporated towns or villages of 2,500 population or less.

Correspondence leading to the selection of the participants in the two-week academy included sending letters to superintendents, media specialists, and principals inviting applications. Follow-up telephone calls by the project director and faculty from the five universities resulted in the selection of elementary teachers, school nurses and administrators/teachers for the summer academy.

Summer Academy Models

Summer academies found to be successful in other states have varied in length. A leadership academy in the Kentucky Community College System included a four-day institute, a fall internship at the participants' home college and two fall retreats (Edwards, 1992). The University of North Carolina held a four-week institute followed by a one-day workshop in the fall (Smith, 1986). Another model included an 11-day summer institute for three summers followed up with inservice days during the ensuing academic year (Kjeldsen, 1988). Still another model entailed a three-week summer institute that included two weeks of academic and classroom activities followed with one week of application of skills learned in a laboratory school setting (Haigh, 1987). Each of the models found increased effectiveness, higher ratings and/or goal accomplishment.

NWREL SCHARP Model

An academy is "a school for specialized instruction." As such, intensive intervention for an extended period is necessary for participants to acquire specialized expertise. Therefore, NWREL chose a two-week length of time for both Academy I (summer 1993)

and Academy II (summer 1994) followed by a year-long internship in the practitioners' own rural school communities. A follow-up meeting of practitioners and faculty was held in the spring. Under the guidance of their state higher education institution, each practitioner carried out their leadership activities. Because of the need to conserve resources, faculty visits to the rural practitioners' schools were limited to those locales which could be visited economically. Telephone contact by the university faculty member in their state, as well as by the project director, continued throughout the year. Written reports of individuals' progress also encouraged interaction of practitioner and university faculty.

Academy Objectives

The SCHARP academies focused on three major objectives:

- Leadership--To increase practitioner skill in serving in a leadership role, to promote and guide health education at the local level; and to maintain resource linkage with higher education institutions, state departments of education and other rural health educators

- Inservice--To improve health training of the elementary teachers and other school personnel, such as nurses and building administrators, so they can lead inservice education for school staff and community members

- Community--To provide community leadership by strengthening the ties between school and community, and by involving parents and community members in health promotion activities

Academic Content

To accomplish the above objectives, the project director and university faculty from the five Northwest states met in the spring to plan the summer academy. The Kolbe model (Attachment A) was used as a content guideline for both Academy I and Academy II. The Kolbe model is widely respected by health educators and provides a comprehensive framework for health promotion. It served as an excellent model for rural elementary teachers whose background in health was limited to health education and/or health methods courses in their undergraduate preparation. Additional determining factors in identifying the academic content were the checklists, questionnaires and needs assessment forms completed by the practitioners prior to attending the summer academy. These helped the faculty in knowing the strengths, weaknesses and status of the school-community health programs in each rural area.

Faculty volunteered to make presentations based on their expertise. In addition to the university faculty, there were presentations by state curriculum specialists, NWREL staff, and individuals or panels of experts on subjects such as equity, resiliency, school services, community resources and computer technology. The practitioners themselves were a

great resource to each other as they possessed individual and unique skills and talents. By the end of the summer academy, each practitioner put together an action plan for their school-community that met the summer academy objectives as well as objectives unique to their specific school-community. Prior to attendance at the academy, the practitioners were encouraged to put together a school-community coalition--a team of school and community members who would not only assist in completing the needs assessment, but who would be supportive and involved in carrying out the action plan. (See Attachment B for an outline of the two-week content of Academy I and II.)

Academy Process

Using research-based techniques to quickly build productive new working groups, efforts were made to personalize the academy, develop a trusting environment, and help the rural practitioners feel comfortable, respected and valued. Activities facilitated getting to know each other. Warm-up activities broke down the formality of the new groups, facilitating trust, improving communication, and increasing learning. Techniques related to collaborative learning were experienced and analyzed. Activities that could be used with students in their own classrooms were used for educational purposes as well as for a physical break. All of the academic content, as well as the process activities, contributed to group cohesion with participants becoming increasingly involved in the process and more confident in their leadership abilities.

A variety of methods were used to model effective teaching strategies that practitioners could use with their students. Assigning a task to partners or small groups after a lecture actively involved them in the lessons and provided an opportunity to apply, question and/or reflect on the information provided. Because each practitioner was to write their action plan before leaving the academy, practitioners worked in small groups as well as alone and with the state university faculty member to complete their action plan.

Location

The 1993 and 1994 summer academies were held in dramatically different sites. Academy I was held on campus in a small university town and Academy II was held at NWREL in the city. Both offered comprehensive school-community health education content, an abundance of resources and materials, and camaraderie. The small-town campus setting offered isolation from outside distraction and encouraged focus on the academy. The NWREL setting provided teachers from a rural setting a chance to experience cultural activities offered by a city and not available in their rural setting. Both the small-town and city settings worked well, each offering their own assets.

Evaluation

Both formative and summative evaluations were included in the summer academy. Following are ways in which faculty and practitioners took part in short- and long-term evaluation:

- Practitioners provided feedback at the end of each day and week during the academy. This written feedback gave faculty the opportunity to make appropriate and immediate changes in content and/or process.

- A posterboard made available daily offered a place to write comments, requests, or questions, providing an ongoing and informal way of collecting data.

- Practitioners at the end of Academy I produced a self-report on their perceived progress in the competency areas identified for Certified Health Education Specialists (CHES). All participants reported significant improvement. (See Attachment C.)

- Practitioners prepared individual written progress reports twice during their year's internship indicating the work accomplished in their school and community. The university faculty were in touch with the practitioners by telephone throughout the year and, where possible, made visits to their schools. These written reports and site visits verified work completed for university credit. It also provided encouragement and accountability for the practitioner.

- At the end of the first year's internship, practitioners in both academies responded to open-ended statements and questions about what did and did not go well during their internship, what was most useful in the academy, and what advice they had for faculty and future practitioners. The responses indicated an increase in knowledge and skill as a result of participating in the academy.

The responses also demonstrated the practitioners' leadership ability, initiative, creativity, hard work and commitment in carrying out each locally tailored action plan with their school-community coalition. The following excerpts from some of the responses indicate the reaction of the groups:

> I believe that one of the most significant reasons for any successes I have had in the projects I attempted and accomplished is that SCHARP provided me with a sense of direction, gave me a chance to develop a plan and the tools needed to organize. Maybe even more important is that I have a sense of who I am, what I can do to improve my community, and a sense that working together, people can improve the outcome, whether in health or other issues. I am also aware of resources that are available to rural communities and that we are not as isolated as we might think. SCHARP gave me a purpose. I have done a great deal of staff teaching on health-related subjects. The most important issue to me was fostering resiliency in kids.
>
> What I learned about coalition building made it happen, beginning with gaining support from my principal, the PTA membership, the community action team and the staff at school. Without creating a spirit of

> cooperation and making sure you are in tune with the needs and desires of the community, you are simply spinning your wheels.
>
> ...(I)t allowed me to create a sobriety club that definitely influenced the students. And of course that came out of my project and I think the sobriety club in the school influenced the community because I'm hearing things all the time from my community, and it's not easy to do that in an Eskimo community. So it impacted the community significantly....
>
> (The planning team)...really got on board and decided...we do have to make some changes; we aren't covering things that are absolutely necessary for kids.... If kids don't have health, they don't have anything. Health is the basic of basics and I think SCHARP helped to underline and focus on that issue.

At the spring follow-up meeting, practitioners formed small groups of four and were asked to identify the four things that impacted them the most. Each group summarized its discussion in a tape-recorded oral report. Following are excerpts showing how the academy affected participants, and what they gained.

> *Leadership* skills that we acquired and put into use. We all had some leadership skills when we came to the academy; they were reinforced and it helped give us what we needed to go ahead and practice them on people, real people. *And materials*--we've all come from areas where curriculum materials are not given to us very freely and so it was nice to be able to say, 'OK, here's our little chunk; let's take it and we're going to use it.' And *community involvement*--it brought an increased awareness and gave an extra shot in the arm to the people who had always been doing things because it brought in other people.
>
> And the perception that *health is more than just body parts*, the body systems, that there's the holistic approach to health with the mental, and one is not more important than the other, they are all interrelated.

In addition to the above forms of evaluation, data was gathered by conducting telephone interviews with practitioners and the faculty in Academy I. Questions were asked to help determine if SCHARP had a lasting effect, along with what and how universities can help the nation achieve the goals set forth in *Healthy People 2000*, a document published by the Surgeon General. Practitioners responses indicated that the SCHARP Project has indeed had an effect upon the schools and communities, and that the effect is continuing. Most reported adopting and implementing a comprehensive, integrated health curriculum of the type advocated by SCHARP. A few described the difficulty of bringing about change because of the nature of the communities, concerns of the administration, or indifference by some of the school personnel. But almost all were upbeat, pleased with what they had done, and optimistic about the future (Savard, 1994).

Summary

Evaluative data collected from practitioners and faculty shows the summer academy was successful in terms of (1) leadership, (2) content knowledge, (3) process skills, and (4) interpersonal networks necessary for promoting comprehensive school and community health initiatives. In addition to quantitative results, there are outcomes of merit beyond the project objectives that are worth noting:

- Teachers made connections with teachers from other states and within their own state, resulting in lasting professional relationships.
- Teachers were exposed to the Internet and are now using or planning to use this technology.
- Participants accomplished SCHARP objectives and their own school-community objectives, and in addition the experience made a positive personal contribution.

Regional academies offer a very effective approach for promoting improvement in small numbers of strategically located sites, particularly in remote rural areas where options for sustained professional development may be quite limited.

II
THE PRACTICUM EXPERIENCE--EXECUTING THE ACTION PLAN

The second phase of the SCHARP model is the guided field experience which practitioners carry out during the school year. In addition to their regular duties in rural schools, the practitioners carry out the steps of their action plans for leading local coalitions to promote comprehensive school health. This chapter describes the university faculty involvement in the summer academy portion of the program.

Recruited, trained at the SCHARP Academy, and armed with their action plans, the participants returned to their respective rural communities and schools ready to begin the school year in which they would lead efforts to bring about a comprehensive school-community health education program. In all instances, this meant developing and convening a school-community coalition, or continuing work with a group previously established to address health education or other school improvement needs and opportunities.

The late completion date of the academy--the end of the first week in August--combined with early school start-up in most of the districts, meant that most of the practitioners actually convened their planning committees somewhere between very late September and early November, with many of the start-up efforts taking place during October. This time lag was built into the action plans completed during the academy and seemed to hold true whether the individual practitioner was starting a new group or beginning the school year's work with an existing group. An analysis of participant journals indicated that the SCHARP-trained participants had "hit the ground running," managing to maintain their enthusiasm and focus throughout the activity and chaos of the beginning of the school year.

Eliciting School Support for Practitioner Efforts

Practitioners were very conscious of the need to build and maintain support for SCHARP activities, since it was clear that their role was to be that of leader-facilitator of the school-community effort, not a one-person whirlwind accomplishing all single-handedly. The main sources of support were to be derived from both school and community members.

School support was needed from three groups--administrators, teachers, and support staff, including itinerant specialists such as traveling school health nurses. In three cases, the practitioner themselves belonged to this latter group, which added an additional dimension to the task of eliciting school support because of the reduced visibility and contact in the school. One practitioner was a school health nurse serving six different schools in rural Montana, increasing her work severalfold in gaining support from schools and communities.

Administrators were brought on board the earliest since, in most cases, they had signed off on their school's participation in SCHARP, and had played major roles in the recruiting and selection of the practitioners. One common kind of administrative support was honoring the use of the $500 grant which was awarded to all SCHARP participating schools. The stipend was to be used to support health education programming across the spectrum of curriculum, inservice, and school-community health promotion and could take the form of paying for released staff time and/or travel, the purchase of curriculum materials, and school-community alliance activities. Although there was some initial concern that the grant might be appropriated by the administration for non-SCHARP activities, this did not materialize and practitioners were free to make creative and appropriate use of the $500.

Another kind of support was administrator validation of the work of the SCHARP practitioner through such things as providing "prime time" at staff meetings for health education announcements and program activities, and through arranging the school environment to support curriculum change and inservice. Principals also provided support by stepping aside and giving the practitioner his or her lead to execute the SCHARP action plan.

Even before attending the academy, with its focus on leadership and coalition building, SCHARP practitioners were aware of the need to enlist the aid of other teachers in their home districts. They also knew that any health education curriculum enhancement could not be promoted as an add-on to the present curriculum. Their strategy was, as one practitioner put it, to use the two "i" words, infusion and integration. Practitioners were successful in gaining teacher support for curriculum improvement efforts in proportion to the benefits perceived by the teachers themselves. Usually these benefits included classroom activities built around health themes which could be used to attain goals and student learning objectives in mainstream subjects such as reading, language, mathematics, and, particularly, science. The use of new materials--books, kits, and models--helped, as did the idea that health education at the elementary level need not be one more add-on to an already crowded plate of curriculum, health, and social services.

Support staff bolstered practitioners' efforts to improve and enhance the health education curriculum. In one school, the food service director, who was also a school bus driver, was a key player in SCHARP activities, helping to build and maintain the school-community coalition from the start. Other practitioners reported similar assistance by support personnel. In some cases, school maintenance staff helped build inexpensive play equipment and generally augmented the limited resource base of the practitioners.

Community Support for Practitioner Efforts

Even though the practitioners were encouraged to focus on in-school curriculum efforts, it became obvious, due to the sometimes controversial nature of the health education curriculum, that it would be necessary to gain community support prior to the creation of scope and sequence outlines and the selection of supporting materials. In most cases, this

consisted of a two-phase strategy. First, coalitions were formed with school and community members. Second, surveys were created and administered to ascertain community interests, needs, and feelings about particular themes and topics in a comprehensive health education curriculum.

Several practitioners reported that these coalitions were critical to gaining acceptance of certain aspects of the curriculum, particularly the human sexuality content, and to being able to move forward to the school-community objective of health and wellness promotion. Where coalitions were less successful, however, activities did not move forward. One example is a crisis-response manual that was initially planned but not developed. Practitioners pointed out problems in communication with community members who were needed to make a success of planned activities and events.

What seemed to help the practitioners the most, in virtually all cases, was at least a neutral posture by the community and often a positive spirit of cooperation with the schools for the mutual benefit of the children. This seemed to be the case whether the practitioner was an established member of the school/community or a relative newcomer. The key was in the early development of a small representative coalition with ties to all major segments and interests in the community.

Seeking Support from Outside Sources

One of the overarching concerns of the SCHARP program staff was with the "one practitioner per district" nature of the program model. Because of funding limitations it was not feasible to recruit, train, and support practitioner teams. In the case of SCHARP, the plan was for the practitioners to return to their district and build their own coalitions and support systems for their programming efforts. Again, due to financial constraints, ongoing, over-the-shoulder assistance by either the university faculty or NWREL staff was only a limited part of the model.

Some of the practitioners, however, developed a support network for themselves, primarily based on correspondence and telephone calls. During the second academy there was discussion about the possibility and feasibility of e-mail communication. This did not materialize because of technological constraints, such as insufficient high-quality telephone lines for computer transmissions, and cost concerns of hardware/software needs, and telephone time needed. At the summative evaluation meeting in March 1995, both groups of practitioners had the opportunity to share stories, successes, and obstacles with fellow practitioners. They agreed that, to maintain an ongoing effort back home over future years, there will be a need for a sustained level of cross-fertilization and support like that experienced during the academies.

During the action-plan implementation year, practitioners had the opportunity for telephone communication with NWREL. Practitioners also submitted journals and other materials to the SCHARP program manager throughout the year, and the manager scheduled onsite visits to the practitioners.

Higher education contact was based on proximity of universities to the school sites and the time and availability of university faculty. Onsite visits were an exception rather than the norm. Practitioners sent journals to faculty and communicated with them by telephone.

One higher education faculty member became an active and helpful onsite participant in response to a practitioner's request. The practitioner, who foresaw potential problems stemming from the wording of a survey question concerning parental views of human sexuality, asked for assistance. In response, the faculty member attended a key coalition meeting. The questionnaire was discussed at the meeting, and the faculty member pointed to likely problems with the survey as constructed. Based on this guidance, the group revised the question and approved the survey. Revising the question avoided creating a circumstance that might have unnecessarily compromised the comprehensive nature of the health education program. While this situation was not common, it does speak to the need for planned, funded support of university faculty for practitioners.

Win Some, Win Some--Assessing the Efforts

By all available measures--practitioner journals and artifacts, program-generated questionnaires and interviews, formal evaluation reports, and the transcripts of the end of year meetings--it appears that the two years were successful. Round One practitioners reported unanimous success in achieving curricular change in health education at the elementary level during the first year. Other elements of the Kolbe model for comprehensive programs and other project goals--inservice and school/community health promotion efforts--took place during the second year of the program. Round Two practitioners--perhaps because of a more efficiently organized academy curriculum--were able to take on multiple program goals with success during their first year.

Not all attempted program activities met with success. There were frustrations and disappointments, such as teachers at the local school site who resented efforts of the practitioner to nudge them forward; community members who didn't seem to hold up their end of the plan; and an occasional feeling that the individual practitioner was alone without support. By and large, however, practitioners felt that they were successful, and all spoke of renewed confidence in themselves as leaders.

In reviewing accomplishments and frustrations of individual practitioners, it is apparent that leadership, like ice cream, comes in many flavors, and that each practitioner worked within a rural context which was quite different from that of anyone else. Each participant brought his or her unique personality, perceptions, and experiences to the task, working with other people equally as unique within a school and community environment which often appeared to have a unique personality of its own. It was this combination of interactions that caused SCHARP activities to be carried out and the program goals to be attained.

The SCHARP Model and the Future

Is the SCHARP model a useful one for the future? Evidence gathered would suggest that it is. The practitioners' successes demonstrate that one person can make a difference and that even limited resources, like the $500 to each school for health education program support, can be helpful in small rural districts. The academy, with its emphasis on the importance and uniqueness of rural contexts, and curriculum focus on developing a facilitative, resourceful, context-wise leader, seemed to be on track both years. Without question, if some modifications had been in place during the school year, stress on practitioners' could have been lessened. These include more sustained communication and networking among the practitioners, and between them and university faculty, and an opportunity for more onsite visits and participation by faculty. Other than these improvements, the SCHARP model seems to have stood the test of the initial pilot stage and round-two replication, and could serve as a basis for continuing efforts to bring stronger and up-to-date comprehensive health education programs to rural schools and communities.

III
SCHARP PROFESSIONAL DEVELOPMENT

In this chapter the first of four variations for adapting the SCHARP model is discussed. The continuing professional development of rural practitioners is a long-standing challenge for all professions, be it medicine, law or education. This chapter explores the role of university faculty and local practitioner expertise in supporting continuing education in isolated areas.

One of the qualities demonstrated by effective schools has been their commitment to and support of staff development programs for their professional staffs. The advantages of professional programs are numerous, but principally focus on creating awareness among staff regarding new teaching concepts, skills, and knowledge with the intention that this awareness will carry over into each teacher's classroom. While larger, more urban schools have been able to access professional development resources with some regularity, rural schools have been less inclined to tap into these networks.

Many opinions have been offered as to why rural schools are less likely to provide professional development opportunities, including the independence of rural schools and a distrust of outside "experts," isolation of rural schools from university resources, and limited funds to finance inservice programs. While each point of view may be valid, there is also validity to the point that rural schools do need and can benefit from an organized staff development plan. Some of the unique qualities of rural schools, such as their isolated locations and small faculty numbers, may create a greater challenge in acquiring outside services, but these are the same reasons that systemic change resulting from a staff development program is more likely to occur in small, rural schools versus larger, urban schools.

Justifying the Need for Professional Development in Health Education

Establishing a staff development plan for health education may create additional problems for rural schools. Health education is considered by many patrons and professional educators as a luxury curricula that they might consider addressing once the "basics" are taught. Others will avoid it entirely because of a misconception that health education automatically means sensitive issues. Some suggest that it is the role of the parents to provide health education, and not the school. All of these points of view reflect the critical need for staff development in health education. In examining the need to consider health education as one of the "basics," one must look at the physical, emotional, and social health of the individual. It is the purpose of health education to help children function successfully within these dimensions of health and thereby help them maximize their potential for all learning.

It is as critical for parents to supplement and reinforce knowledge and skills taught in health education as it is for language arts and math. To successfully facilitate the positive development of health behavior, it is critical that school health programs establish a partnership with the home in the teaching of health education.

Many of the misconceptions surrounding health education are due, in part, to the limited preservice training for elementary education majors and the endorsement standards adopted by state departments of education. Most standards in the Northwest require little more than a general health class for endorsement at the elementary level. While a general health class may give an overview of societal health issues they cannot, in a single semester, provide an indepth understanding of those issues or the methodologies involved in teaching health education and in constructing health education curriculum.

Interestingly, the lack of progressive endorsement standards in health education by state education agencies is in conflict with many of their own elementary school program standards which require or recommend the teaching of health education throughout grades K-6. Understandably, teachers with such limited preparation shy away from providing instruction in a curriculum for which they are not prepared, be it science, health, or geography.

Further complicating this preparation dilemma is the limited inservice available through universities and state education agencies. Unfortunately, the pressure on university faculty to publish research as the major criteria for promotion and tenure has forced faculty to give service in the field a low priority. Many state education agencies, while sponsoring occasional staff development opportunities through regional and state conferences, have become primarily regulatory in nature as resources for technical assistance dry up.

The Higher Education Role in Delivering Field Services

Positive Influences. The SCHARP Project has served as a positive vehicle for delivering inservice education to its participants on basic health educator competencies, with the intention that these skills would be utilized at the local level once practitioners returned to their home school districts. Partnerships with universities which deliver inservice training have been an important element for both the training associated with the SCHARP Project, as well as assisting the practitioners to deliver inservice training to their home schools.

SCHARP faculty represented universities throughout each of the Northwest states of Alaska, Idaho, Montana, Oregon, and Washington. Faculty members served in multiple roles over the three years of the project, including teacher, facilitator, administrator, mentor, resource broker, advisor and friend. While these roles are common to teacher-student settings, it is uncommon to find inservice providers assuming all of these roles for their participants. With these multiple roles present, SCHARP practitioners learned not only new information and skills, they were also the recipients of critical feedback and follow-up throughout a one-year period from an established university faculty member.

Traditional one- or two-day inservice programs generally do not provide this much attention over such an extended period of time.

With universities often providing the leadership for health education within each state, it became apparent throughout the SCHARP Project that, without the higher education partnership, rural schools and communities would be left without the skills and resources necessary to facilitate long-term systemic change in their health education efforts. The information highway has the potential to bring the isolated rural school onto a level playing field of resource identification and access now enjoyed by larger districts, colleges and universities. At present, the universities are in a better position than isolated rural schools to identify state, regional, and national resources which complement health education program efforts. Assisting rural schools with the identification of resources to address health education needs, universities create a linkage which provides payoffs in terms of healthier communities throughout their state as well as a positive public perception of what universities are about and can do for them. At a time when significant public perception holds that universities are ivory towers with little connection to the "real world," it seems advantageous to consider the positive merits of university, school, community networks.

Another important facet in establishing a process for this change at the rural school was the provision of continuing education credits for teachers participating in staff inservices. Credit opportunities created by the SCHARP Project ranged from developing health curriculum for their schools to inservice on specific health issues, such as stress management, which focused on skills applicable to the practitioners as well as how to address such topics in the K-12 classroom. Many of the health education inservice requests by schools are motivated by school or district teams attending school site wellness conferences held annually in each of the Northwest states as well as across the country. Rural and urban districts participate in these conferences, returning home with detailed action plans for overhauling or enhancing their health education programs. Universities would be wise to capitalize on this motivation by providing the follow-up leadership and inservice credit which can aid schools with the implementation of their action plans. Collaboration on efforts such as this is one more opportunity for universities to demonstrate their commitment to establishing partnerships and networks which enhance their image as important players in systemic change.

Barriers. Delivering the SCHARP Project encountered barriers. The first barrier was that of professional isolation experienced by rural professionals. Often the rural teacher is miles away from educators in other districts with whom they can network; even more frequently they are many miles away from higher education resources with whom they can collaborate. This isolation frequently evolves into an independence which is both commendable yet limiting. It is commendable in that the schools learn to "fend for themselves," yet limiting because it hinders help from outside resources even before they are asked. Rural educators then find it easy to say, "We don't have the time, or the resources, to consider change and we are too far away for anyone else to help". The reality of separation by distance does not have to mean that rural schools are too isolated

to network with and/or receive outside help from regional, state or national resources. Growing numbers of regional, state and national health education resources are being made available to all schools throughout the country regardless of size and location, many times for limited cost and sometimes at no cost. The first key is to make a commitment to address health issues, the second key is to identify potential resources, and the third key is to ask.

The most difficult barriers associated with higher education are the university promotion standards. University faculty are awarded promotions based on their achievements in research, teaching and service. At a time when surveys are indicating that the American public wants professors spending more time on teaching than on research, most universities remain unchanged in their expectations for promotion with the greatest weighting placed on research followed by teaching and finally service.

The ultimate purpose for research is to explore what we do not yet know about a given subject and to enhance what we do know. In health education, we do know that the more hours of instruction children have on a health issue, the more likely they are to practice the associated health giving behaviors. We also know that the majority of teachers at the K-8 levels have little or no preservice training in health education and consequently do not teach it in their classrooms. If we are to truly benefit society through health education, then the knowledge revealed through past and present research must be taught as early in the lifespan as appropriate. At present, we as a society are incapable of delivering this benefit and will remain unable to do so until the field practitioners responsible for delivering this new knowledge receive the appropriate training via preservice and inservice, with higher education as the major provider. Investing in new research without first establishing a delivery system for the completed research seems foolhardy at best, questions the value of health education research at worst, and becomes incapable of paying dividends in terms of a healthier general public.

Another barrier encountered by the SCHARP Project was the joint collaboration of school and community. The school has frequently functioned as a community center in small, rural communities. While this collaboration is often times a strength, delivering health services to school and community becomes a challenge uncharacteristic of other projects. The SCHARP practitioner came from either a school or community health background, seldom both. The problem presented was how accepting would educators be of a school/community health nurse directing school health curriculum development, and how accepting would community health professionals be of an educator directing the development of a community health service plan. The training provided by the SCHARP academy focused on leadership skills, and on planning processes versus specific health knowledge. This focus enabled the practitioners to return home, enlist the support of key school and community leaders, and to initiate the developmental processes necessary to facilitate needed changes. Although it took time to establish the appropriate networks within the community, and time for SCHARP practitioners to become accepted as leaders in an arena different from their professional past, this barrier was successfully managed by all practitioners by the end of their first year.

Practitioners were also schooled on potential funding resources to help alleviate the limited fiscal support available to health education efforts. They were pleasantly surprised at the funds currently available through various departments of education, health, and human services. While the continuation of these sources is not assured, many corporations remain interested in health issues as well as community and school projects. Discovering these potential sources can allow SCHARP sites to continue supplementing the limited funds available from local sources.

Depending on each community's needs, controversial issues may find their way onto the agenda, issues such as HIV/AIDS, sexually transmitted diseases (STDs), sexuality, drugs and alcohol, physical and sexual abuse, among others. SCHARP participants returned to their communities with the skills to facilitate long-term systemic change within their school and community health programs while at the same time remaining sensitive to the mores reflected by their community. The management of the barriers presented by controversial issues was once again found in the process taught through the SCHARP academy. It required that a community-wide needs assessment be conducted utilizing methods which allowed community-wide ownership in the final product. Soliciting input from all points of view regardless of their diversity was a necessity for the adoption of programs which are intended to serve an entire community. As with any community, resistance to change was encountered by all SCHARP sites. The wisdom of SCHARP practitioners to make a number of small changes over a long period of time, versus a major change in a short time, is consistent with successful change strategies. The hope of SCHARP faculty is that SCHARP participants and their communities will maintain their focus on the long-term goals while continuing to implement the smaller process goals in the years to come.

The final barrier for SCHARP sites will be sustaining long-term improvement--a responsibility which rests with each community's coalition and ultimately with the community itself. By rotating the responsibilities of chairing the coalition, communities can reduce the burnout which frequently afflicts many project leaders. Maintaining the same leadership year in and year out is not necessarily harmful, but the recruitment of new leaders for the coalition, and for special health events such as health fairs, curriculum projects, and other activities, establishes a broader pool of community members from whom the project can draw for support over a period of several years. Finally, the community as a whole is responsible for providing the assurances necessary to keep health program needs on the "front burner." As a society we are discovering that it takes an entire community to raise a child. Does it not also make sense that it takes an entire community to improve that community's health standards?

Other Potential Delivery Strategies

The SCHARP academy is but one method of delivering health education training to the rural areas. Other delivery strategies are capable of providing similar success. The benefits and capabilities of distance learning have been well documented in the recent past and continues as an important, viable means of delivering training to rural, isolated areas. It does require that the rural site invest in the necessary linkages with their state public broadcasting network or other distance-education providers.

Two of the strengths of the SCHARP model were the face-to-face interaction and the periodic follow-up with a mentor. The distance learning model may not be able to deliver face-to-face interaction directly to the rural site, but may be able to convene several trainees at one central location which has the appropriate technology. One-on-one mentoring is very possible provided that university faculty are willing to take on the responsibilities. Numerous possibilities allowing for follow-up include e-mail, telephone, FAX, conference calling, and regional health networks.

Self-directed study is another possible method of delivering SCHARP-like training. The first prerequisite, however, is to find a university which will provide some of the training under independent study, and/or practicum or internship credits. Few things in this world are certain. One, however, which remains certain is that it is the individual's responsibility to learn. Self-directed study is based on that premise and that the best motivation for the adult learner comes from within. This philosophy further requires the professor to assume the role of a facilitator versus the role of teacher, an enviable position for an educator who believes in promoting learning as a lifelong positive adventure.

A third potential for training may be through SCHARP-like, grant-funded academies within each state or collaborative efforts between state universities, state departments of education and/or health and human services.

Evaluation

The evaluation conducted of SCHARP supported its design (Savard, 1994). Continuation of this model after the present grant expires is unlikely, however, without the support and guidance of higher education. Although other state agencies such as state departments of education and health and human services can also serve as catalysts for academies within each state, ultimate success depends on the universities which provide the credits and the professors/mentors.

Informal evaluation conducted by NWREL and the SCHARP faculty indicated that university credit was an important factor in practitioner decisions to become involved in the project and was an extremely critical factor for the successful implementation of action plans for those districts who were able to procure university credit for health curriculum development and inservice training.

One modification suggested by Savard (1994) was to "include a team of one school person and one community person, rather than the single school-related person" as called for in the original model. Adoption of this modification may reduce the time it takes for the practitioner to achieve credibility within the community for directing efforts for which the practitioner was not previously trained. It may also reduce much of the "aloneness" that practitioners experienced upon their return by establishing a colleague focused on the same health goals and objectives and one who can provide insight to their arena of expertise, be it school or community.

Thus, professional development plays a central role in the SCHARP model by instilling leadership skills among practitioners to improve community health norms in rural areas. Higher education faculty play a central role in preparing these practitioners, as well as delivering preservice and inservice education for educators as a whole. Yet, it remains questionable whether there are sufficient resources and public commitment to the well being of children to continue higher education support of rural professional development initiatives.

IV
PROFESSIONAL RECOGNITION, ACCREDITATION/ ENDORSEMENT

A second variation on the SCHARP theme relates to the leverage to be gained from establishing a professional endorsement for the rural comprehensive health facilitator role. Policy standards, such as school accreditation and professional credentialing, prove a mechanism for legitimizing institutional functions. In rural areas, there is not an economy of scale necessary to support specialization of roles or institutions. Hybrid, more generalized skills are needed. In this section, the professional recognition and endorsement of the rural comprehensive school health education facilitator are proposed as a method for supporting and sustaining this role.

Little has been done to wed the world of comprehensive health education and the world of rural education. Comprehensive health is a critical and indispensable part of education lacking in many of rural communities. At times this lack of a program is by conscious choice, but often the lack of a program is because none of the professional educators in the school system have the knowledge or skill to conceive and implement such a program. The SCHARP grant has attempted to validate a model of professional development to enable a K-8 classroom teacher or other school personnel to gain the knowledge and skills necessary to fulfill this need. While it is important for a professional educator to acquire these skills, it is also important to formally recognize this accomplishment.

Role

The role of the rural comprehensive health education facilitator (RCHEF) is truly a hybrid role. The facilitator is not, at the outset, a health educator. Often, the facilitator is a classroom teacher who may or may not have had any formal training in health education. If the facilitator has any background in health, it was probably in the form of a single health class in the teacher's required education curriculum.

To a certain extent, the RCHEF must take on the roles of a health educator, an administrator, and a curriculum leader. By definition, one who is a facilitator should expedite, aid, assist, empower, enable, and validate those with whom the facilitator is working. In order to be effective, this hybrid role of comprehensive health education facilitator must indeed be a little bit of everything.

There is currently no way to formally recognize the RCHEF role and its associated abilities. However, there is no consistent endorsement process in the nation or region upon which to build RCHEF certification.

As the SCHARP Project began, university faculty and NWREL staff thought that the academy format would provide sufficient training and disseminate sufficient knowledge for the practitioners to be able to qualify for the Comprehensive Health Education Specialist (CHES) certification. However, before the first academy was held, requirements for CHES certification changed, making preparation through the academy impossible.

While preparation for CHES certification was no longer an objective, CHES competencies still played a major role in the determination of academy content and evaluation. The purpose of the SCHARP Project was not to prepare elementary teachers and nurses to be health educators, but rather to prepare these practitioners to be rural comprehensive health education facilitators. The broad knowledge needed in health education was not necessary for these practitioners in their schools. They needed to know how to promote the total scope of comprehensive health education and how to facilitate a process for members of the school and community to achieve health related goals.

Need for Recognition

The foremost reason for needing formal recognition is quality assurance. Formal recognition requires an approved set of standards or expectations. With formal recognition, everyone knows what abilities and skills an RCHEF must have. Schools, other professionals, and parents understand the role and function.

Standards come about as a result of the best collaborative work by a group of knowledgeable professionals. In its simplest form, proposed standards undergo intense scrutiny by other professional associations, educators, and the general public. After input from all interested and affected groups, a set of standards is eventually adopted. Once the standards are in place, then all institutions responsible for educating professionals in that area incorporate the same knowledge and skills in their respective programs. Good inservice can be defined in terms of the scope of what is taught by the accredited institution or in terms of what has been learned by the certificated graduate.

Formal recognition would serve as validation of the role. Currently, the RCHEFs in Northwest rural schools lack this type of validation of their position. These individuals attended an intense two-week academy in preparation for their role as a comprehensive health education facilitator. Respective administrators validated their role first by sending them to the academy and second by supporting the types of changes that must take place in the curriculum. However, a title bestowed upon these individuals in the form of an endorsement would give immediate recognition of the role of RCHEF. Formal recognition as an RCHEF is a recognition of professional abilities. Teachers receive recognition for teaching areas, for specialized areas of expertise such as reading, mathematics, special education, and library skills, among others. The role of RCHEF requires a wide variety of skills and should be recognized for these professional abilities. Recognized roles and functions show up on school budgets.

Type of Recognition

Formal recognition of the role of RCHEF is not appropriate as an undergraduate endorsement/certification. To be an RCHEF, one must have had some experience in the school setting as a nurse, administrator, or a teacher, and some informal recognition as a "leader" in the school. As an undergraduate student in any discipline, these experiences are not common. An undergraduate typically does not have the knowledge about how the school system works, who is most likely to get things done, the politics of the area in terms of what is going to be accepted, and how to get things accepted in the community. While experience is no guarantee that a comprehensive health education curriculum will be developed and accepted, the road to success is made more smooth if the training that leads to becoming an RCHEF begins after the trainee has some school experience upon which to draw.

Currently, the RCHEF role may not be appropriate as an endorsement/certification area. Areas currently endorsed/certified have an identified body of knowledge. As described previously, the RCHEF draws on the literature of many fields. There is not a sufficient theoretical basis for this to be offered as a specialization area for graduate level work. As mentioned previously, there would be great difficulty in standardizing requirements for certification among the states. An RCHEF needs to know about comprehensive school health education, administration and leadership skills, community health, coalition building, advocacy skills, organizational skills, and other areas. While knowledge in all of these areas is essential to success, total command of each is not necessary. Conversely, someone trained and certified in any one of the areas would still need additional training in order to be an RCHEF. The hybrid role is necessary and therefore makes this area most difficult to define as an endorsement/certification area. There would not be sufficient credit hours for either a major or a minor area of study.

The political difficulties of adopting any type of endorsement/certification for the position of RCHEF would be quite formidable. Professional associations from state to national levels would likely oppose formal recognition of any type of position that deals with health education. Since the RCHEF is not trained as a health educator and is not expected to function exclusively in that role, health educators would be concerned that the RCHEF is not qualified to work with health curricula. Until the RCHEF position is more clearly defined and understood, this political difficulty will remain. School districts large enough to be able to afford to hire a certified health educator would benefit from someone who has had RCHEF training, but would not have the same level of needs as small rural K-8 schools. Additionally, most certified health educators are employed in secondary schools and are not available to elementary schools to implement a comprehensive school and community health education program.

Looking toward a time when endorsement/certification for RCHEF may be more likely, the SCHARP Project practitioners have begun to identify areas of study, skills, and knowledge needed to be an effective RCHEF. The benefits of the RCHEFs are now being seen in the various sites. With the successes in the field, it should be somewhat easier to

begin talks with various players--associations, universities, health educators, administrators--about the recognition and need for someone with these professional abilities.

Means to the End

How do we best prepare the RCHEF for success? A variety of ways exist. SCHARP has shown we can get to the outcomes of school/community rural comprehensive health education under very adverse conditions. Schools in the rural Northwest were chosen for this project because of their extreme ruralness. They all, on some level, lacked resources--both fiscal and personnel--to dedicate to implementation of a new curriculum. They did not have a health education specialist, and in many cases the schools represented multiage, multigrade situations with only one or two teachers, without an onsite administrator, and with families of diverse political and religious beliefs who are spread over a wide geographical area. In spite of these constraints, the SCHARP model worked. Preparing practitioners for their own specific community settings through the practicum experience works well.

Another alternative might be the professional schools model. The current model of professional development schools faces a difficult barrier. The rural nature of the majority of the schools in the Northwest area poses a distance barrier that make it very difficult for a close working relationship to exist between a university and a school. This barrier can be overcome with the continuing advances in telecommunications technology, but it still poses special problems. Collaborative partnerships cost considerably both monetarily and in terms of the time commitment on the part of both partners. Rural schools may find it very difficult to commit the amount of time and money needed. Release time is often an issue and is not one that will be easily solved in the rural areas. Even if the money to pay for release time is not an issue, finding substitute teachers is. Bureaucratic constraints imposed by a professional development school model may hinder the flexibility needed in the hybrid role of an RCHEF.

Why does the SCHARP model seem to work? Perhaps the number one issue that makes this model attractive is the amount of time a person must commit for preparation. The SCHARP model asks participants to commit to an intense two-week academy. For many of the participants, two weeks during the summer is an acceptable length of time whereas four to eight weeks is not. Because of the shorter amount of time, the financial commitment is somewhat less. By working through a higher education institution's continuing education program, the academy can give credits. For some participants, these credits may count toward a master's degree. For others, these credits count toward an increase on the pay scale. The SCHARP model may create opportunities for university faculty to generate extra income during the summer in a short period of time and provide the opportunity for research and service activities. The academy model provides continued professional development for teachers and faculty alike. Reports from the academy participants indicate that this provided an opportunity for retooling, revitalizing, and re-energizing public school personnel.

Offering programs through institutions of higher education allows formal evaluations to be an integral part of practitioner preparation. Classes are offered as part of a departmental program or they are sponsored by a department and offered as continuing education programs. In either case, the RCHEF preparation is subject to regular and accepted practices of institutional evaluation. Classes are evaluated by the sponsoring department's faculty to ascertain if the content is appropriate, if the faculty meet the department's criteria, and if the amount of work being proposed is consistent with the number of credits being offered for the class. As the classes are taught, the instructor is evaluated by those enrolled in the class as to their level of preparedness, knowledge of content, method and effectiveness of delivery, and helpfulness of written assignments and readings among other items.

Is there a place for a rural comprehensive health education facilitator in the professional scheme of things? Is this position important? Is this position necessary? What is the importance of this position versus a health educator? Through SCHARP grant activities, answers to these questions and many more are beginning to be answered. Participants agree that the RCHEF concept has made an impact on their schools and their communities. This position was not developed to take the place of a health educator, it was designed to fill an enormous void where a health educator does not exist, a health education program does not exist, and where health needs in the school and community are not being addressed. Until there is a major shift in priorities, there will always be a need for an RCHEF, a health educator, or both in the public schools and particularly in the rural schools of America. The RCHEF is not the enemy of the health education profession just as the physician's assistant is not an enemy of the medical profession. Rural schools are in desperate need of help and, at this time, that help must come from the community and from within the schools as they are structured.

V
EXTENDING THE SCHARP MODEL THROUGH AVAILABLE TECHNOLOGY AND EXTENDED DELIVERY EDUCATION

When looking back on an educational endeavor of this type, it is necessary to address the question of whether the goals of this project could have been met through a different means. This chapter will briefly review what was successful, what was not, proffer reasons for those wins and losses, and suggest ways that the objectives of SCHARP can be met using today's technology to optimize learner time and resource expenditure. In particular, the professional isolation experienced by educators in remote rural areas has the potential of being countered by emerging communications technology.

While the SCHARP experience never attempted to replace a course of study in health education such as necessary to receive CHES certification, the goals aspired to were parallel but specific to the needs of the rural practitioner within the limited scope allowed by two-week academies. Practitioners acquired skills and knowledge that would allow them to develop comprehensive health curriculum with their communities; methodology of teaching specific to health education; health content; and information relating to the healthy school-community environment.

According to many of the follow-up evaluations from the practitioners and the subjective feelings of the faculty involved in the project, the greatest successes of SCHARP were accomplished in the area of leadership. The leadership modeling resulting in both the sharpening of necessary interpersonal skills for leading their schools and communities to a healthier end, and the feeling of empowerment in the practitioners when they returned to their communities, were felt to be valuable outcomes of the SCHARP experience. Additionally, the belief in the importance of health education conveyed through their contacts in the two-week academy increased the motivation of many of the already highly motivated practitioners to do the extra work necessary upon returning home.

Strengths of the SCHARP Model

The immersion of the practitioners with a team of professional health educators for the two-week SCHARP academy would seem to be responsible for a significant portion of the project's accomplishments. There are not many inservice opportunities in which a student can spend two weeks with six regional leaders at a student/faculty ratio of three to one. Faculty selected to represent the participating state institutions of higher education brought strong and diverse backgrounds to the task. Community expertise pertinent to specific goals of the project were also drawn in during SCHARP. What this meant for SCHARP practitioners was a two-week opportunity to avail themselves of resources they

felt would meet their needs in leading the assault on the health problems of their communities and schools.

Not only were the practitioners exposed to lectures, demonstrations, discussions, and other varied learning experiences during their many 10-hour class days, practitioners, faculty, and NWREL staff took breaks and ate lunch together. Both by design and by the personal styles of several faculty, interaction with the practitioners by the faculty was extensive. Outside of class hours and time spent on assignments, practitioners often devoted their leisure hours to time with faculty.

While the high level of faculty-practitioner interaction was extremely important in meeting the goals of SCHARP, the amount of information learned from fellow practitioners due to their shared immersion in SCHARP and common work experiences were also invaluable. Practitioners--often with very similar needs because of their shared rural problems--had varying perspectives about the health goals they wanted accomplished in their schools and communities. Their degree of understanding about health, health education and school-community service integration also varied as did their ideas of what they thought were the means for overcoming the roadblocks facing all of them. They were excellent resources for enabling each other to meet the project goals.

The interaction between practitioners and their state's faculty after they returned to their school-community sites was another success--although limited--of the SCHARP model. In instances where the amount of interaction kept the practitioner and faculty member involved together in meeting the practitioner's action plan for the year, it was usually because of the physical proximity of the faculty member's institution and availability for communication. While attempts by the practitioners to seek help were most always met, remoteness of sites from the state higher education institution involved in the project was inversely related to further unstructured interaction.

Another strength of SCHARP was the rewards the practitioners received for participation in the program. The inexpensive graduate credit the practitioners received for participation somewhat assured their continued involvement during the year. This was possible because the granting institution had no support expenses other than the paperwork necessary for registering the SCHARP practitioners and recording their grades upon completion of their year. While enrolling for credit enhanced the chances that the practitioners would comply with the action plan developed during the academy, the funding of their trips to the summer academies and the mini-grants to their schools only indirectly supported project compliance, the associated practitioner and school-community development. The funding enabled involvement by several of the participants, but had little influence on the completion of project goals.

Weaknesses of the SCHARP Model

The first weakness of the model is the cost. If just the travel expenses were shouldered by practitioners and the salaries of the faculty by a sponsoring university, this project would not have come to fruition. Most state institutions do not offer special courses outside of the normal curriculum unless it at least breaks even. SCHARP, as modeled but with normal tuition charges, would not generate enough income to even pay for faculty salaries.

Another weakness of the SCHARP model is that many teachers, staff and administrators have trouble giving up valuable summer vacation or, in some instances, supplemental income time, to attend a two-week course.

While communication between faculty and practitioners was required through various assigned reports, upon leaving the summer academies communication was for the most part very limited. Reports were mailed through the postal service. Questions, information and resource requests were handled by phone conversations. The busy and often conflicting free hours of the faculty and the practitioners did not lend themselves to frequent and direct communications during the practicum school year.

Available Technology and Extended Delivery Education

Alternative communications technology holds promise for assisting in the delivery of the SCHARP program. The following brief discussion summarizes some of those areas and looks at how these mediums might be used to help deliver the SCHARP program.

Correspondence Course. Extended delivery education to rural sites is not new technology. Agricultural and vocational education have been brought to areas separated from the centers of higher education throughout this century. While many types of knowledge can be effectively learned through assigned readings mailed to learners, followed with an evaluative mail-back tool, enhancement of this "correspondence" course through some type of media has enriched that process for the learner. Technological advances in mass communication, such as the telephone, radio, and television have been incorporated to give rural residents increased access to knowledge that empowers. With statewide television broadcasting such as the Rural Area Television Network (RATNET) in Alaska, students may learn through viewing broadcast television programs. A widely known example of a media-enriched correspondence course was Jacob Bronowski's series "Ascent of Man," broadcast nationwide on the Public Broadcast System. A number of institutions offered correspondence courses using the text of the same name and mailed test materials. With the proliferation of video recording and playback machines in the 1980s, enrichment through the use of video tapes mailed to the students became possible. Each of these types is labeled as "correspondence " courses because mail service is relied on to move materials and information from the center of higher education to the learner.

Audio Conferencing. The use of two-way synchronous conversations between learners and teachers based at more than one site has resulted from advances in telephone switching that allows for more than one connection. This augmentation of the learning experience is still widely in use today as the learners from the rural sites call in to a "bridge" number. Wen all are hooked up, the instructor mediates a session in which knowledge may dispensed, assigned readings may be interpreted, questions answered, and evaluation may take place. The instructor or "facilitator" of such sessions must be well trained in using this mode of learning to optimize the technology and the time spent by everyone involved.

Video Conferencing. Much more recently, advances in use of digital transfer of video signals and the hard-wiring of the connections for such transfer has increased the use of video-conferencing by both institutions of higher learning and other large units interested in the training or communication within its organization. Several states have set up networks of a limited number of sites around the state so that people can " meet" and carry on face-to-face conversations with people at the other sites across the state. With the addition of the visual information to the auditory, learning can be enhanced for all with a specific benefit for the visual learner. The richness of communication between all the participants can also facilitate learning beyond the cognitive goals of that course. However, this technology is still very expensive and thus limits the number of rural sites available.

CD-ROM and Interactive Media. CD-ROM technology, presently available in most of the personal computers sold today, can drastically change the means of learning from that of traditional serial delivery of information through the means described above. Because CD-ROM technology allows the user to access information anywhere on the disk almost instantaneously, a learner can move through a course according to his or her own needs. The linear progression that may bore the student entering with prior course, or stifle the learner who needs remedial help, is unnecessary with this technology. Through Hyper Text Markup Language (HTML) key words in any section can be linked to other sections to accommodate knowledge levels of various degrees. With the huge amount of information--encyclopedias, for example--that can be put on a CD-ROM, both courses *and* their background readings and evaluative material fit this media. With a modern personal computer, this text can also be highly enriched with visual and auditory presentations. Course material placed upon a CD-ROM can be used according to the individual learner's learning style, the amount of entering knowledge possessed, and what the goals of the learner are.

Digital Communication by Electronic Mail and File Transfer. While phone conversation is synchronous (it necessitates all the individual's participating in it to be present at once), electronic mail or e-mail works in an asynchronous mode as does postal mail. The main difference is the amount of time necessary for the mail to be sent and received. E-mail is transmitted almost instantaneously. In fact, e-mail conversations occur between and among many individuals all over the globe through the Internet. To access the Internet and e-mail requires a terminal, a modem and some type of server to a

network. The problem that most rural users presently face in becoming connected to a network is that the server they need to call up usually requires a long-distance call. However, more and more institutions of higher learning--all who are connected to the Internet--are deciding to meet their land-grant service missions to their state by developing networks with toll-free calls that connect to their servers. Private institutions are also realizing that credit hours can be produced regardless of proximity if students can access a server, and thereby professors and courses.

Many of the logistical and cost problems faced in communication between university faculty and the rural practitioners in SCHARP would be eliminated through use of electronic mail and networking.

With communication greatly increased through simple e-mail and electronic discussion groups, the transfer of information electronically would be the next technological step in delivering what is available for the on-campus learner to the rural student. File transfer protocols can be used to download and upload course materials, resources, and even tests. Just as CD-ROMs use hypertext to link different pieces of information, electronically-prepared courses can do this also.

Proposed Alternative to Academy Delivery of SCHARP

Blindly rushing after technology is as inappropriate as adhering to the principle of "if it works, don't fix it." The SCHARP Project generally worked. All involved--faculty, practitioners, and NWREL staff--would agree, however, that it could have worked better. If the goal of empowering rural educators to effect increases in the health of their schools and communities is to continue without the money and resources of the sponsoring federal grant it worked under, a different model must be adopted. This model must consider how to meet the strengths achieved in this project, shore up the problems perceived here, and meet the resource requirements for delivery. A combination of much of the content and process of SCHARP with existing and evolving educational technology could allow a continuation of this quest.

While it is not possible here to flesh out the details of such an educational offering, some suggestions can be made as a starting point. First, the breadth and the depth of content knowledge related to health and health education would lend itself easily to being linked through HTML on either CD-ROM technology or in a site on an accessible network. The up-front cost of developing the hypertext could potentially be outweighed by the reduced cost of remote delivery. Use of this technology can assure that all learners have the information necessary to perform the tasks at hand. Additionally, this technology allows for formative evaluation processes to occur when and where deemed necessary by the learner. Summative evaluation, either for learner grading or for course evaluation and development, can also be easily embedded into this technology and greatly reduce faculty evaluation time.

Secondly, communication technology, including both audio and video conferencing and electronic mail, should be included to allow the development of some of the leadership and interpersonal skills resulting from this project. The feelings of the participants in SCHARP of their empowerment as leaders resulting from this experience may not be limited to face-to-face development. Experiences that are as easily structured for the electronic meeting place may bring about those results and may even do it more powerfully. While personal interaction is thought to be desirable in accomplishing many of the leadership, motivational and interpersonal goals related to being a health educator, it is yet to be proven that enhanced technological contact cannot do the same. Until such a time, the economic benefits offered by technology, including economy of faculty and learner time and of learner and institutional dollars, necessitate exploring combinations of how the course of study is delivered.

The electronic meeting place offers considerable hope for reducing the barriers presented in this world by such arbitrary barriers as resources, and geography. National boundaries or rural/urban distinctions don't exist in cyberspace. Rural residents who many times are denied easy access to developing their full human potential because of their remoteness have an opportunity to stand on the same footing as their urban counterparts. The information relating to their personal and community health now lies much closer to the rural resident due to today's technology. Those who take the next step should utilize the tool of technology as both rural health and the power of rural people to access and to affect their world will be enhanced.

VI
SCHARP: Opening the Door to Systems Change

The majority of policymakers, educators, and the public at large agree that public education needs reform. However, the nature and extent of changes are discussed and debated. Some promote the newest curricula, the latest teaching innovation, or the freshest administrative style (Sashkin & Egermeier, n.d.). Others regard these approaches as piecemeal solutions that "tinker at the edges" of the real problem (Reigeluth, in press). The real problem, they say, is an ailing education system requiring fundamental, systemic changes through basic restructuring (Corbett, 1990; O'Neil, 1993; Reigeluth, in press; Sashkin & Egermeier, n.d.). These two approaches bracket a solution continuum ranging from minor adjustments on one end to basic restructuring on the other. In this chapter, we explore the relationship of the SCHARP model to this continuum, whether SCHARP can support the processes necessary for fundamental change, or whether its potential contribution is nearer 'tinkering at the edges.'

Systems Change in Education

> If there is a common thread among the various interpretations of systemic change, it is a belief that change in one component of a system affects everything else in that system--and that various pieces of the system must be better aligned toward achieving common ends. If some components of the education system are left untouched, 'the pieces that aren't changed drag schools back to the old system'. (O'Neil, 1993, p. 10)

O'Neil's statement on systemic[1] change introduces not only its major distinguishing characteristic, but also the very element that makes successful change of this type so difficult. In successful systems change, all aspects of the system must move forward (Anderson, 1993); change in one aspect of the system requires changes in other aspects (Banathy, as cited in Reigeluth, in press). To produce the reciprocity of relationships critical to successful systems change, everyone in a particular educational system--students, teachers, administrators, policymakers, and parents--must be involved in the change process, content with the changes made in their roles as a result of the process, and willing to engage in the professional development necessary to work effectively in their new roles within the system (Reigeluth, in press).

The common sense of shared ownership characteristic of systems change demands decentralization of traditional administrative structures. The locus of control shifts from

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[1] As used in this chapter, the terms systems change and systemic change refer to the same concept. The terms are used interchangeably both to reflect their actual usage in the literature and to reflect the preference of the particular author being cited.

individuals external to the system (e.g., funders, curriculum experts, political leaders) to people residing and working within it (St. John, 1992). As decentralization occurs, people within the system gain the ability to make the staffing and resource allocation changes necessary to support and sustain the new system (Sashkin & Egermeier, n.d.).

Ultimately, if the principles of systems change are upheld and the basic restructuring that needs to occur is allowed to take place, the process is expected to result in an education system characterized by an appreciation of interconnectedness, an emphasis on shared decision making, and a focus on active learning (Anderson, 1993). Members of the system are motivated by shared self-interest. Dialogue and conversation hold sway over lecture and information giving. System members have the freedom to experiment (and to fail); self-sufficiency is fostered. The focus is on long term capacity building--both within the school and within the community. Rather than evaluating success by measuring the extent of deterministic impacts and outcomes, standards of success focus on quality of process and interactions (St. John, 1992).

The Challenges of Systems Change

As the previous discussion implies, systems change can represent change of such magnitude that, in effect, the previous system passes away and a new system emerges in its place. Vision is important in the presence of such immense transformation (Corbett, 1990; Smith & O'Day as cited in O'Neil, 1993); models are indispensable. So it's puzzling when efforts to locate examples of successful systems change efforts--including descriptions of the guiding vision and models used--bring one up empty handed. A brief search of the literature on systemic reform shows that there's a sizable gap existing between what's being said about systems change and what's being done to produce it. There are very few actual examples of sustained, systemic change within the nation's schools (Wagner, 1993) and no new model of systemic change exists that "has been field tested, debugged, and proven effective" (Reigeluth, in press). Even descriptions of the basic patterns underlying systemic change are hard to find (Anderson, 1993). What does this gap between theory and practice mean?

In all likelihood the gap indicates the demanding and uncertain nature of systemic restructuring. As mentioned previously, the reciprocal nature of systemic reform is particularly challenging in that it requires both initial buy-in from all members of the system and access, early on in the process, to the lion's share of resources necessary to support systemic change. Of the resources necessary, the most important is probably also the scarcest--time (Wagner, 1993).

> Time for teachers and students to get to know one another. Time for parents and community members to become involved in children's learning. Time for leaders at all levels to reflect and plan collaboratively. Time--perhaps five years--to rethink the purposes of education, reinvent teaching and learning, and create new school cultures. (p. 28)

Practically speaking, most districts simply don't have this amount of time. Neither do they have the other resources, nor the broad-based support necessary to make the huge commitment systemic reform requires.

Even if these basic prerequisites are met and systemic reform is initiated, in the absence of a proven model, there is no guarantee that the newly restructured system will be more capable of meeting the challenges facing it than the system it replaces. This brings the process full circle as without a model in which members of the system can place their confidence, it becomes impossible to obtain their support. Without their support adequate resources, including time, won't be made available. The circle is not only completed, it proves to be a vicious one, preventing the process from ever getting off the ground.

The goal here is not to list the many factors involved in creating the gap between the theory and practice of systems change in education. Rather, it is to illustrate, through use of a few key examples, the daunting nature of the systems change process. Once this is understood, the gap between theory and practice can be appreciated. It is also much easier to understand why the majority of attempts to address the crises in public education continue to make adjustments within the present system. Until proven models and successful examples of sustained systemic reform provide education leaders with evidence that it offers the solution to the crises they are facing, they will have no reason to call for, or support, systems change. Indeed, given its inherent demands, education leaders will have every reason to continue making changes within the confines of the present system--for while piecemeal solutions and tinkering at the edges of the problem may be ineffective, they are familiar and safe.

So where does this leave us? Does it all boil down to a forced choice between fundamental restructuring and superficial, piecemeal, tinkering, or are other options available?

This leaves open the possibility that viable solutions to the crises in public education need not necessarily fall only at the systems change end of the continuum. It also leaves open for consideration the possibility that a model located somewhere between the extremes may serve as a precursor to systems change, setting in motion the chain of events necessary for fundamental reform to follow. We believe this is indeed possible and that it is possible with SCHARP. In the next two sections we explore three ways in which SCHARP can serve as a precursor to systems change and we provide actual examples of systems-style change that occurred during the course of the project.

The SCHARP Model and Systems Change

There are at least three ways in which SCHARP may open the door to systems change. First, the entire SCHARP effort is organized around comprehensive school health, a concept that is arguably broad enough and worthy enough to provide the vision necessary to guide systemic reform. In addition to the vision of providing for students' general health and well-being that comprehensive school health provides, field tested and proven

models for the actual development of comprehensive school health programs are available to assist districts in taking the steps necessary to move toward their vision. If a school district committed to this vision decided subsequently that it wanted to go beyond the goals of comprehensive school health in its restructuring efforts, the models available could be adapted to provide an adequate point of departure for even broader change.

Second, as its title signifies, SCHARP was developed specifically to explore the efficacy of the school-community partnership. One of the basic challenges that must be addressed in efforts involving systemic change is building and sustaining the broad base of community commitment and involvement necessary to support the change process (Sashkin & Egermeier, n.d.). Increasing numbers of people are beginning to appreciate the interconnections between school failure, underachievement, and related health and social problems. As awareness increases that these problems create "serious repercussions not only for children and their families, but for their communities and ultimately for the nation's economic and social systems as well" (Lavin, Shapiro, & Weill, 1992, p. 213), development of a program devoted to protecting and improving the health and well-being of students (and ultimately the communities in which they live) will be a goal around which increasing numbers of teachers, parents, and communities can rally. SCHARP's focus on comprehensive school health can provide an excellent avenue through which community commitment can be built and sustained.

The third way in which SCHARP may open the door to systems change is through its design, which teamed rural education practitioners with university faculty members in their states. This pairing created a system of school-university connections in five states that encouraged university faculty to work hand-in-hand with rural practitioners to develop programs to address the particular health concerns of their school districts. Faculty helped link practitioners in isolated districts with services and resources and provided them with the background necessary to develop school/community connections and to serve as advocates for health. Practitioners provided faculty with a wide array of opportunities to apply their health education expertise to meet the needs of a particular rural district. In forging these links, the SCHARP model has encouraged different interest groups within the education system to work together to bring about change and has demonstrated the power of involving all interested members of the system in the change process. Additionally, SCHARP has succeeded in establishing a network of connections that can be added to and used in future restructuring efforts.

Opening the Door to Systems Change: Examples

As the discussion of SCHARP's connection to systems change has been largely theoretical thus far, and as practical examples of the change brought about in participating rural districts probably provides the best evidence that SCHARP has opened the door for system change, this chapter closes with project examples of change and comments from the rural practitioners and faculty members who worked to bring the change about. To maintain continuity with the previous section, these examples have been grouped to

provide illustrations of the three ways in which SCHARP may open the door to systems change.

First, through the use of comprehensive school health, SCHARP provided practitioners with a sense of direction, or vision, offering them a model to develop an integrated plan for change and the tools needed to organize for it. As one practitioner stated when asked about the lasting effects of SCHARP, "Mainly it is a greater understanding of the importance of health as a precondition to success in any line of endeavor. In my classroom we really do have health education running across the curriculum." Most districts involved in SCHARP adopted and implemented a health curriculum based on the principles of comprehensive school health (Savard, 1994). In one district, the administrative team agreed to give priority to comprehensive school health for the following year's funding. In another, a community nursing clinic was organized in association with the regional public health service. Open twice a month, the clinic provides comprehensive health services, consultation, and education to people of all ages.

SCHARP encouraged the development of school-community ties on both a formal (the summer academy) and informal (conversations between faculty and practitioners) basis. One of the summer academy's central goals was to increase participants' awareness of the reciprocal relationship between school and community. During the academy, case examples illustrating ways in which schools and communities worked together to forge new ties and to create innovative school-based services that better suited community needs were shared. Discussions, role playing, and skill building activities on related topics including leadership, coalition building, and conflict management were also covered. Practitioners left the academy ready to address one of the central challenges in systemic change: building and sustaining a broad base of community support. During their year of implementation they gained practical insight into the importance of a strong community support base.

Many had never attempted to work closely with parents or community members and were surprised at what a powerful resource this support base proved to be. Time and time again they commented on the importance of establishing strong school/community ties. The following comments on the topic, taken from SCHARP Project evaluations (see Savard, 1994), illustrate how impressed the practitioners were.

> It is really important to get the school administration and the community involved ... School board support is very important--they really want to know what's going on.
>
> This is really the first time that I have ever had parents seriously involved. It works.
>
> Many of the problems faced by university faculty communicating to rural students in the SCHARP program would be eliminated through use of

> electronic mail and networking. My advice is to get to know the community before you start and involve them all the way--start to finish.

> The main thing is that you have to know the people and get the right ones involved at the right time doing things they like and can be successful doing.

> Do what we did! Bring all the staff, community members, and students together and develop a comprehensive health curriculum and service program. It works.

One district succeeded in developing a community action team that was so effective in its work townspeople began turning to it for assistance on other concerns. As the practitioner in this district commented, "The townspeople are seeking the aid of the community action team and seem to recognize us as a group that represents their needs." Developed as part of the SCHARP Project, these school-community linkages lay the foundation for the broad based community support so vital to systemic reform.

While perhaps less impressive in their overall impact than the previous two components, practitioner-faculty teams also proved to be an helpful resource. In particular, the teams helped address the sense of isolation that is so widespread among rural practitioners. Faculty were available to practitioners when they ran out of ideas or grew discouraged. Consultations between faculty and practitioners during these times gave practitioners the support they needed to continue on with their efforts. As one practitioner commented, "I am much more aware of resources that are available to rural communities and that we are not as isolated as we might think." This comment also refers to a second challenge faced by the practitioners--lack of resources.

Faculty encouraged practitioners to be as creative and innovative as possible when developing resource lists. A comment from one faculty member illustrates both the challenge of securing adequate resources and the creative thinking that took place around this issue.

> The rural practitioner is being faced with more and more "urban" type problems as more poor people move to rural areas because they cannot survive in the cities .... Rural areas don't have the resources to deal with these problems. We are trying to get schools to team up with other agencies to coordinate services. The rural school is a natural center for coordination--but resources are lacking.

Summary

While the SCHARP model is not a systems change model it can, as this chapter has tried to show, open the way to systems change. Organized around comprehensive school

health, SCHARP offers a worthy vision and a well tested model for making that vision a reality. With a design that emphasizes school-community ties and practitioner-faculty pairings, SCHARP creates a broad base of support for changing norms.

Educational leaders in favor of systems change tend to overlook the possibility that moderate approaches, those located on the solution continuum between the extremes of fundamental restructuring and piecemeal tinkering, may help pave the way for subsequent fundamental reform. In an imperfect world, one that challenges the all-or-none integrity of systems theory with the practical constraints posed by cost, time, and support, the SCHARP model offers a proven, workable alternative and a possible first step in the larger restructuring process.

VII
LESSONS LEARNED

This guide was written in an effort to share lessons from the SCHARP Project experience with other professional educators who are planning comprehensive health programs for rural schools and communities through leadership training of local practitioners. The first two chapters of the guide discussed the academy and practicum aspects of the model. Chapters three through six explored ways of adapting or extending the approach through professional development, certification and endorsement, communications technology and systemic change strategies. Yet, there are additional lessons of a more general nature learned by the faculty and practitioners which may prove useful to the reader. These observations are organized around rural communities, rural schools, time and other resources, practitioner needs and faculty needs.

Rural Communities

Rural communities are extremely diverse in nature and vary from each other as they do from their metropolitan counterparts. Yet, the SCHARP Project repeatedly encountered several qualities in the participating communities.

- It is common for communities to ascribe expectations and responsibilities upon individuals, who then become the victim, villain or hero of an effort, depending upon the outcome. Burnout of such leaders is frequent. Shared ownership for the effort can be curtailed.
- The norms of rural communities depend upon local leadership and tradition. Some may be characterized as independently minded and rigid, while others may be described as flexible and innovative. It is a mistake to make assumptions about the mores of a community, particularly if community members are expected to support a local initiative. Neither can it be assumed that communication is open and free-flowing. Communities may be as internally isolated as they are from other places.

- Communities tend to have more resources (agencies, people, library, films, etc.) than they tend to realize. Community members need training in how to find additional resources. In any case, human resources remain as the most important asset. Communitywide authentic involvement is the key to success. "...(K)now the people and get the right ones involved at the right time doing things they like and can be successful doing."

- The facilitator for school/community efforts should have training on how to build coalitions and generate trust among parents, the community, and the school. A needs assessment must be done to determine community priorities in a visible, public process.

Rural Schools

Rural schools are extremely diverse. The small size of many of these schools, coupled with their geographic distance from other places, create interesting microcosms of human dynamics. There are few staff and even fewer hours in the day with which to learn and apply novel ideas.

- A continuum exists from fear and resistance to apathy to zealous support for health and well being. It is important to understand that school goals must be carefully balanced within these extremes. Individual's personal agendas can interfere with improvement efforts, including the aformentioned fear, apathy or support for alternative priorities. For example, teachers may have a lack of understanding that comprehensive health education is to be infused into the curriculum, not treated as an add-on subject.

- Because of limited resources and conflicting priorities, facilitators of comprehensive school health must be motivated by intrinsic rewards. Currently, their role and additional responsibilities can rarely be validated by monetary incentives. Faculty and staff are generally very busy and may be reluctant to become involved in staff wellness activities or other extra duties.
- It is easier, but less effective, for teachers take on the role of 'expert' and not involve the community in deciding curriculum issues. Collaboration is a time consuming, difficult business which is essential for successful program implementation.

Time and other resources

Rome was not built in a day. Neither was a comprehensive school health program. It will be the ingenuity, tenacity and unflagging commitment of individuals which make the long-term measureable differences in rural schools and communities.

- Large amounts of time are needed to organize a school/community project. Finding time for committees to meet is very difficult. Approving and implementing any change is a time consuming and sometimes discouraging process.

- "You can't ever relax and expect the project to succeed. You always have to have one more meeting--even if you are tired of the effort." Start slowly and build; pace yourself--avoid burnout. Know that it generally takes more than one year to get underway with program implementation..

Needs for Practitioners

The Rural Comprehensive Health Education Facilitator is armed with a reserve of organizational, communication and coalition-building skills to guide community health enhancement efforts. Without these tools for building a local support base, health content knowledge will have little effect.

- Validation of role as a leader or facilitator for change in the school/community project will come through networking with other professionals experiencing similar problems and successes.

- Set realistic goals in home districts--bite-sized pieces, prioritize and be pleased with slow steady progress--be realistic. Keep focused on the commitment to kids. Be flexible, 'roll with the punches,' have alternate plans. Anticipate roadblocks whenever possible to avoid as many problems as possible. Delegate, delegate, then delegate a little more.

Needs for Faculty

In spite of the obstacles of tenure-track, limited resources and isolation from rural areas, higher education institutions are expected to provide leadership in the preservice and inservice development of professionals, including rural educators.

- Utilize more experienced personnel as opposed to undergraduates in teacher preparation programs as participants in the academy setting.

- Use short intense settings for training academies rather than regular coursework for continuing professional development.

- Use previous participants to help teach new participants--it helps to have been through the process when talking with others.

- Develop more partnerships between public schools and institutions of higher education so both the IHE and the schools have additional resources upon which to draw.

- More clearly define what a Rural Comprehensive Health Education Facilitator is and what this person is expected to do.

- Make sure participants have more preparation before attending an academy or training session.

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ATTACHMENT A

The Allensworth and Kolbe Model

Allensworth and Kolbe's Model: Eight Areas of Comprehensive Health

You believe that health is important and that something should be done about starting a comprehensive health program in your school. Now where do you start?

There are many definitions of comprehensive school health programs depending on your own perspective and the needs of your community and its children. As we were planning what to do at our own schools when we returned home from our training, we chose to follow the recommendations of Lloyd Kolbe (Allensworth and Kolbe, 1987) who suggested eight components in developing a comprehensive program.

This section is separated into eight Allensworth and Kolbe components. The first thing you'll discover is that they all overlap. In almost everything you do for comprehensive health in your school, you'll find that some other area is involved to make it successful. Health instruction can be enhanced by specialists in health services, your physical education classes, support services within the school, and integration with resources in the community. You are already doing many of the things necessary to make a comprehensive health program effective and functioning in your own school. Now you have to establish some consistency across the grade levels and school years, and you're on your way! The Allensworth and Kolbe model will help keep you accountable to areas you feel [illegible] important. We took ownership of those for our[illegible] but you will have to decide how much emphasis to place on each area, and which ones are important to your community.

What is involved in each area? Here are some guidelines to consider:

1. School Health Services

- Prevention, intervention, and remediation of specific health problems
- First aid, illness, and injury attention
- Services for handicapped/disabled
- Personnel: nurses, doctors, and dentists
- Service and education for staff

2. School Health Education

- Curriculum (sequential, developmental, and integrated)
- Goals that promote and develop wellness, behaviors, and attitudes, and add to knowledge

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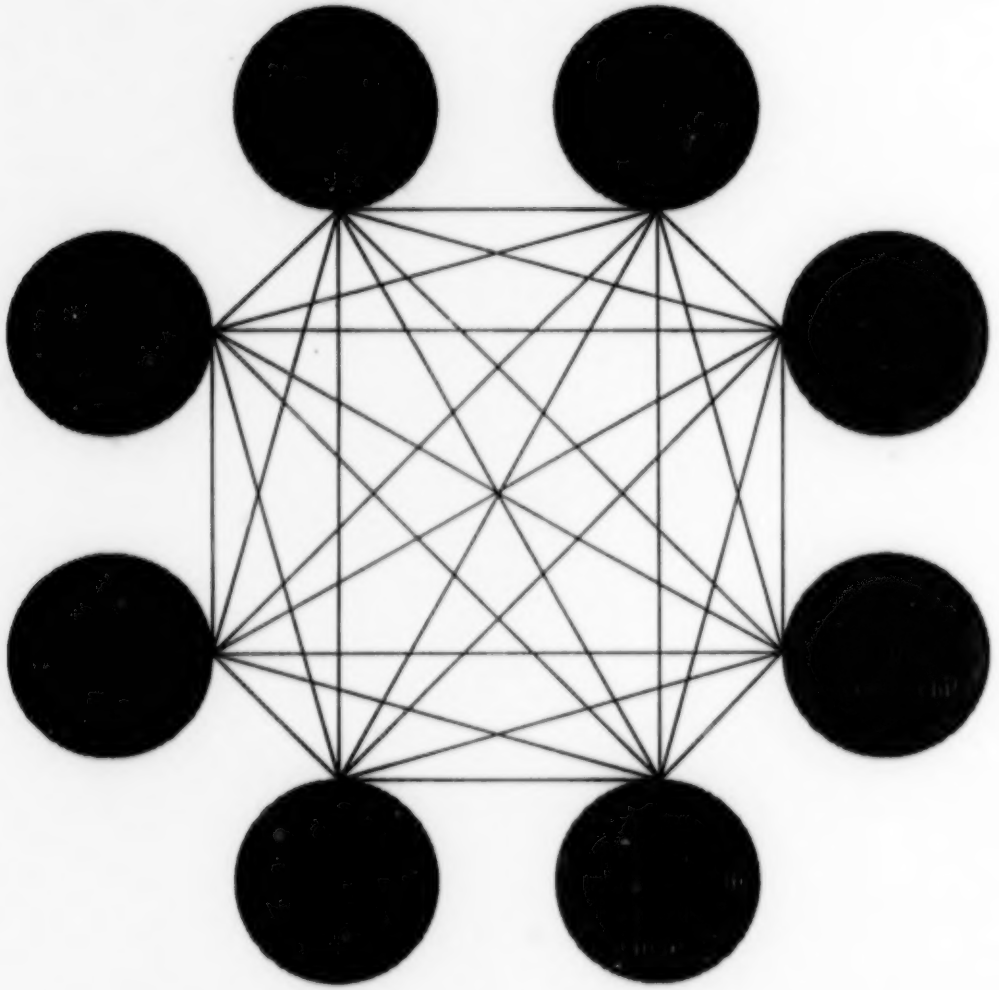
Allensworth and Kolbe's Model



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Topics to consider:

a. Accident prevention and safety

b. Community health resources

c. Consumer health

d. Family life education

e. Mental and emotional health

f. Environmental health

g. Nutrition

h. Personal grooming

i. Disease prevention and control

j. Substance use and abuse

3. School Health Environment

- Psychosocial environment, and school climate
- Physical conditions of school (humidity, noise, light, heat, and ventilation)
- Physical safety for staff and students
- Sanitation
- Site and location

4. Integrated School and Community Health Promotion Efforts

- Outreach from both sides
- Integrated, cooperative, and overlapping programs
- Collaboration
- Community activities on school sites and school activities on community sites

5. School Physical Education

- Health related fitness
- Motor coordination and performance
- Self-expression and social development

6. School Food Service

- Breakfast, lunch, and snacks available at schools
- Nutrition education

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hool Counseling

- Counseling/vocational guidance
- Broad-based interventions
- Assessment/evaluation to improve performance or adjustment to school
- Implementation of special provisions and laws (i.e., IEPs, 504 plans)

8. School Site Health Promotion Program for Faculty and Staff

- Programs and services for staff
- Employees active in maintaining health to improve productivity and provide role models

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ATTACHMENT B

Outline of Academy I and Academy II

Academy I
July 25 - August 6, 1993

OVERVIEW SCHARP ACADEMY TOPICS/EVENTS

SUNDAY 25 JULY CHECK IN 1:00-5:00 DORM ORIENTATION 7:00 PUB	**SUNDAY 1 AUGUST** 6:30 - 9:00 – RESILIENCY WESTERN CENTER PRESENTATION
MONDAY 26 JULY KEYNOTE BIG PICTURE PROJECT OVERVIEW ACADEMY EXPECTATIONS RURALITY EVENING -- GETTING TO KNOW YOU and STATE NIGHT	**MONDAY 2 AUGUST** SCHOOL/COMMUNITY #1. SCHOOL/COMMUNITY #2. EVENING – GENERAL SESSION
TUESDAY 27 JULY LEADERSHIP NEEDS ASSESSMENT COALITION BUILDING EVENING -- TWO STATES	**TUESDAY 3 AUGUST** SCHOOL/COMMUNITY #3. 12:30 FOOD SERVICES 2:30 ACTION PLANNING EVENING: OPEN FOR NOW
WEDNESDAY 28 JULY 8:30 -11:30 SCHOOL HEALTH ENVIRONMENT AND PHYSICAL EDUCATION 12:30 - 3:30 C AND I #1. EVENING -- TWO STATES	**WEDNESDAY 4 AUGUST** LEADERSHIP SCHOOL HEALTH SERVICES AND COUNSELING EVENING -- SHARE ACTION PLANS
THURSDAY 29 JULY C AND I #2. 12:30 PROGRAM EVALUATION 2:10 DIVERSITY EVENING--DIVERSITY SPEAKER	**THURSDAY 5 AUGUST** WORKSITE AND COMMUNITY HEALTH PROMOTION MOTIVATION/COMPLIANCE FOR WELLNESS STRATEGIES SHAPE UP ACTION PLANS/ETC. EVENING – PARTY NIGHT
FRIDAY 30 JULY C AND I #3. Jane C AND I #4. Jane EVENING -- RCHEPers/Jane Q&A	**FRIDAY 6 AUGUST** PRACTICUM EXPECTATIONS WRAP UP SYNTHESIS/QUESTIONS CHECK-OUT DETAILS EXIT AFTERNOON
SATURDAY 31 JULY 8:30 - 12:30 CONTROVERSIAL ISSUES, ETC. Jane	

Academy II
July 26 - August 5, 1994

DAILY CALENDAR - ACADEMY II
SUMMER 1994

WEEK ONE
July 26 - July 30

Sunday, July 24
Faculty meeting 1:00 - 5:00PM NWREL

Monday, July 25
Introduction: HJ morning
Getting to Know You: All
Rurality: Bob (1 1/2 to 2)
Journaling: Leslie (30 minutes)
Round Table & Brainstorm: Rick (one hour)

Tuesday, July 26
Community: Identify major concerns, sensitive issues, community, parents view
(Leslie, Rick, Max)
Integrated Services: Overview (one hour) - Bob
School & Community: School as Community Center (ALL, morning)
Cultural Diversity & Other Handicaps, SES: Tom (rest of PM)
Expansion of Diversity: Max (PM)

Wednesday, July 27
Leadership: Miller McBride (Tom)
Coalition Building: Leslie (1 - 1 1/2)
Needs Assessment & Evaluation: Rick, Kathy (rest of afternoon)

Thursday, July 28
Introduction: Action (2 hrs. AM)
Action Plans Activity: Bob
Resiliency: HJ (all PM)
Practitiioner Visit: evening,

Friday, July 29
Leadership II: Community Conflict (Leslie, Kathy, PM)
Program Evaluation: Bob, Kathy

Saturday, July 30 9:00-1:00
School Health Environment: Tom, Max
Physical Education: Tom, Max
Garden of Eden

WEEK TWO
August 2 - August 5

Monday, August 1
Food Services: Sharon John (8:30 - 9:45AM) (Rick--fill in on Wed if more is needed)
Curriculum & Instruction: What is curriculum, scope and sequence (Max, I hr, AM)
More C & I
Agency materials Les, Max PM 2:00-3:30 PM
Interaction With Sharon and Action Plan Time--states: evening

Tuesday, August 2
County Health Agencies Michael
School/Community Health Promotions: Rick
Motivation Compliance: Rick
Controversy Panel, Role Play: Rick (evening)

Wednesday, August 3
School Health Services: Rick
Pat Eck: Family Services
Work on Action Plans

Thursday, August 4
Final state meetings
Review next year procedures and format
Academy Evaluation: HJ
Integrated Services: Jack

Friday, August 5 end at noon
Academy review
Evaluations
Closing

ATTACHMENT C

Practitioner Self Report

SCHARP PROJECT

HEALTH EDUCATION RESPONSIBILITIES AND COMPETENCIES FOR PRACTITIONERS

For each of the following competencies, please assess yourself in terms of where you were in your abilities before the academy started (WERE) and where you are now after having attended the majority of the academy (NOW). Please be reminded that our expectations are not that you will be an expert and know everything at this time, but we want an idea of what you believe you have gained in a very short period of time.

You are asked to rate each competency from 1 to 4, with 1 indicating you do not feel competent in that skill area, to 4 that you feel very competent in that skill. Your complete honesty with yourself and us is necessary. Don't feel bad about yourself if you must mark 1s. On the other hand, give yourself credit where credit is due and mark the 4s where appropriate.

RESPONSIBILITY I - COMMUNICATING THE CONCEPTS AND PURPOSES OF RURAL HEALTH EDUCATION

COMPETENCY A: Describe the discipline of health education within the rural school/community settings.

Scale: 1 = Do not feel confident 4 = Feel very confident

SUBCOMPETENCIES:	WERE	NOW
1. Describe the interdependence of health education and the other components of a comprehensive school health program.	1 2 3 4	1 2 3 4
2. Describe comprehensive school health instruction, including the most common content areas.	1 2 3 4	1 2 3 4
COMPETENCY B: Provide rationale for K-6 (K-8) health education.	1 2 3 4	1 2 3 4
COMPETENCY C: Explain the role of knowledge, skills, attitudes, and environment in shaping patterns of health behavior.	1 2 3 4	1 2 3 4

COMPETENCY D: Define the role of the rural school and community members within a comprehensive school health education program.

SUBCOMPETENCIES:		
1. Describe the importance of health education.	1 2 3 4	1 2 3 4
2. Summarize the kinds of support needed to implement a school/community health education program in a rural community.	1 2 3 4	1 2 3 4

Scale: 1 = Do not feel confident 4 = Feel very confident

	WERE	NOW
3. Summarize the kinds of support needed by the K-6 (K-8) teachers from administrators and others to implement an elementary school health education program.	1 2 3 4	1 2 3 4
4. Identify available quality resources for health education in a rural community.	1 2 3 4	1 2 3 4
5. Describe the importance of modeling positive health behaviors.	1 2 3 4	1 2 3 4

RESPONSIBILITY II - ASSESSING THE HEALTH INSTRUCTION NEEDS AND INTERESTS OF ELEMENTARY STUDENTS

COMPETENCY A: Utilize information about health needs and interests of students, school and community.	1 2 3 4	1 2 3 4
COMPETENCY B: List behaviors and how they promote or compromise health.	1 2 3 4	1 2 3 4

RESPONSIBILITY III - PLANNING RURAL SCHOOL/COMMUNITY HEALTH PROGRAMS

COMPETENCY A: Select realistic program goals and objectives.	1 2 3 4	1 2 3 4
COMPETENCY B: Identify a scope and sequence plan for K-6 (K-8) rural school health instruction.	1 2 3 4	1 2 3 4
COMPETENCY C: Plan health programs which reflect the abilities, needs, interests, developmental levels, and cultural backgrounds of rural schools and communities.	1 2 3 4	1 2 3 4
COMPETENCY D: Describe effective ways to promote cooperation with and feedback from administrators, faculty, parents, and other interested citizens.	1 2 3 4	1 2 3 4
COMPETENCY E: Determine procedures which are compatible with school policy for implementing curricula containing sensitive health topics.	1 2 3 4	1 2 3 4

RESPONSIBILITY IV - IMPLEMENTING RURAL SCHOOL/COMMUNITY HEALTH PROGRAMS

COMPETENCY A: Employ a variety of strategies to facilitate implementation of a rural school/community health program.

Scale: 1 = Do not feel confident 4 = Feel very confident

SUBCOMPETENCIES:	WERE	NOW
1. Provide a core health education curriculum.	1 2 3 4	1 2 3 4
2. Integrate health and other content areas.	1 2 3 4	1 2 3 4
3. Incorporate topics introduced by students into the health education curriculum.	1 2 3 4	1 2 3 4
4. Utilize affective skill-building techniques to help students apply health knowledge to their daily lives.	1 2 3 4	1 2 3 4
5. Involve parents in the teaching/learning process.	1 2 3 4	1 2 3 4

COMPETENCY B: Incorporate appropriate resources and materials.

SUBCOMPETENCIES:		
1. Select valid and reliable sources of information.	1 2 3 4	1 2 3 4
2. Utilize school and community resources within a comprehensive program.	1 2 3 4	1 2 3 4
3. Refer students to valid sources of health information and services.	1 2 3 4	1 2 3 4
COMPETENCY C: Employ appropriate strategies for dealing with sensitive issues.	1 2 3 4	1 2 3 4
COMPETENCY D: Adapt existing health education curricular models to community and students needs and interests.	1 2 3 4	1 2 3 4

RESPONSIBILITY V - EVALUATING THE EFFECTIVENESS OF THE RURAL SCHOOL/ COMMUNITY HEALTH PROGRAM

COMPETENCY A: Utilize appropriate criteria and methods for evaluating outcomes.	1 2 3 4	1 2 3 4
COMPETENCY B: Interpret and apply evaluation results to improve rural school/community health programs.	1 2 3 4	1 2 3 4